Extra-Uterine Hæmorrhage in Parturition.

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EXTRA-UTERINE HÆMORRHAGE IN PARTURITION.

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This is one of the most anxious complications of labor. Fortunately it seldom occurs. Many an obstetrician of extensive hospital and general practice has never met with a case, and medical literature on this subject is correspondingly meagre. In the year 1830, Deneux, of Paris, wrote an able article on Blood Tumors of the Vulva and Vagina, which called forth during the following thirty years many other articles on hæmatocele, hæmatoma, hæmophilia, varix, and other subjects relating to *pathological* hæmorrhages in the puerperal state, by M. Nélaton, M. Huguier, M. Récamier, and M. Bernutz, in the *Archives de médecine*, June, 1848, and 1857; the *Bulletin*, June 4, 1851; and M. Bernutz's *Diseases of Women*, vol. i. Much later, Dr. Tilt, Dr. Hewitt, and Dr. Simpson wrote on kindred subjects; also Matthews Duncan, in the *Edinburgh Medical Journal*, November, 1862; but none of these describe exactly the kind of case intended by this article.

Dr. Tuckwell, of Oxford, writing on Effusions of Blood in the Neighborhood of the Uterus, 1863, ably describes

the condition in general, but as resulting from various causes other than the conditions and processes of parturition.

I desire to call attention in this article to extra-uterine hæmorrhage induced by the conditions and processes of parturition—parturition mature, or parturition premature—abortion, miscarriage, or full-term labor.

The causes of intra-uterine and extra-uterine hæmorrhage in parturition are similar, except in location and expression, the one being within and the other without the uterine organ. Tumors, hæmatocele (effusion of blood into the pelvic peritoneal cavity), hæmatoma (effusion of blood into the pelvic subperitoneal cavity), hæmophilia (abnormal tendency to hæmorrhage), varix (venous dilatation), and tissue necrosis are among the infrequent causes; but that tubal "menstrual flux," or rupture of the Graafian follicles or parovarian sacs, could produce hæmorrhage in labor, or from labor, taxes credulity. The pre eminent causes are ectopic or extra-uterine gestation and maternal and instrumental efforts in delivery, from ruptured tissue or burst blood-vessels, usually accidental and non-pathological. Tubal abortion and tubal rupture are fruitful causes of this form of hæmorrhage. If from tubal abortion, the hæmorrhage must necessarily be within the first weeks of pregnancy, for while the tube is being gradually dilated about the impregnated ovum, the fimbriated end is being correspondingly contracted by the general congestive, hypertrophic, and hardening influence of the process of gestation on the unsupported termini of the tube, inclosing the fimbriæ and occluding the tube during the first two months of gestation. The hæmorrhage in this case is into the peritoneal cavity. If from tubal rupture, the hæmorrhage occurs at the time of rupture, which may be at any time during the puerperal state; and if tubo-ovarian (above the peritoneal covering), the effusion is into the peritoneal

cavity; but if the rupture is in the bottom of the tube, the hæmorrhage is into the folds of the broad ligament, and in either case it must result in absorption, inflammation, or encasement, with new environments in some of the more pendent portions of the body—viz., the utero-vesical, the præ-vesical, or Douglas's pouch.

While ectopic gestation is to be regarded as the most frequent cause of extra-uterine hæmorrhage in parturition, we must not pass unnoticed the rarest and gravest accident in labor—rupture of the uterine walls—which usually proves fatal to both mother and child. There may be hæmorrhage from a pre-existing adhesion, from infiltration, submucous or interstitial, into the walls of the vagina and vulva, from varicose veins, from fœtal or instrumental injury, from depraved tissue and abscess.

Diagnosis.—The symptoms indicating concealed hæmorrhage are sudden pain, shock, thirst, pallor, sighing, gasping, chills, sweat, restlessness, tossing of the arms, begging for help, dilated pupils, dimness of vision, rapid, tense, and contracted pulse, and subnormal temperature. The local and subjective symptoms of extravasations of blood into the substance of organs, areolar tissue, or internal cavities are swelling, dullness on percussion, displacement of organs or parts, succussion, and discoloration.

Treatment.—In extra-uterine hæmorrhage from tubal abortion or rupture, however much one might crave surgical interference for extricating the displaced fœtus, for reducing the tubal rupture, and for removing the extravasated blood, yet, as a thing is important according to its utility, surgery is not at first most important, because it can not be utilized. The condition that presses for attention above all others and demands immediate help is the systemic shock. The shock necessarily defers operation. Ergot and aromatic sulphuric acid in full doses should be

given and continued; and trillium erectum, one drachm of the tincture in hot water every half hour, in connection with ergot or alone, should be administered; while subcutaneous injections of ether, brandy, or whisky, at a temperature of 110°, with copious draughts of hot water with a little table salt in it to sustain the volume of arterial fluid, hot milk diluted with hot water, beef tea, or hot gruel, with external heat to prevent collapse, should be pushed with energy, remembering that the chill of the shock is in itself devitalizing.

Nothing steadies and sustains the nervous system in shock better than subcutaneous injections of morphine, and a quarter of a grain should be given as soon as possible. Darkness, fresh air, and quiet are favorable conditions.

The first ray of hope in the case is recovery from the shock, the second from absorption of the extravasated blood, and the third from fœtal extirpation or capsulation. After recovery from the shock the treatment will be indicated by the determination of the effusion and products of conception. Surgery here may prove most useful. Should the effusion be intraperitoneal, the most probable determination is into the pouch of Douglas, whence it can be withdrawn by careful aspiration—a comparatively safe operation with the use of an aseptic aspirating needle fitted to a self-delivering hypodermic syringe, thus preventing the introduction of air into the peritoneal cavity. The products of conception in this case must be dealt with, if at all, by surgical interference.

Should the effusion and products of conception lodge in the broad ligament, cœliotomy is indicated, but without operation a fatal termination is by no means certain. Many spontaneous recoveries from this accident have been recorded, as well as many patients who in after years, as Dr. Watts says in his hymn, "Live at a poor dying rate," the

cause of their impaired health pointing to this anomaly. Dr. Mann recites a case of fifteen years' standing where the fœtal remains were removed from the pouch of Douglas, and this was followed by recovery. Other authors speak of fœtal remains abiding capsulated for twenty, thirty, and forty years.

For preventing or overcoming inflammatory action, sitz baths of a temperature of from 70° to 80° F., for from ten to eight minutes, combined with the foot bath, of a temperature of 110°, or an ice bag over the affected region, with antiphlogistic remedies, are indicated.

Should hæmorrhage in parturition occur from rupture of a hæmatocele, hasty delivery and sustaining the patient are all that is required at the time "The mere presence of a large amount of blood in the peritonæum," says Thomas (*Diseases of Women*, p. 498), "does not warrant evacuation. If, as time passes, suppuration . . . and septic absorption are manifested, . . . the mass should be discharged by incision."

Should there be rupture of the uterine walls, says Playfair (*Midwifery*, p. 392), and "the fœtus be entirely within the uterine cavity, the proper course to pursue is to deliver at once *per vias naturales*, either by turning, by forceps, or by cephalotripsy." If the child has escaped into the abdominal cavity, gastrotomy offers the best results, as is shown in Jolly's tabulated statistics of 564 cases:

Treatment.	No. of cases.	Deaths.	Recoveries.
Expectation.....	144	142	2
Extraction *per vias naturales*.....	382	310	72
Gastrotomy.....	38	12	26

In natural labor the extra uterine extravasation will drift along the course of the rectum and vagina, and, if extensive, will obstruct the fœtal progress, the ultimatum of

which will be rupture of the vagina, vulva, or perinæum before delivery. As aspiration is better than rupture, it should be employed, and as far away from the genitalia as possible, to avoid subsequent sepsis. A case in hand will illustrate :

I was called to attend a lady, aged twenty-seven years, healthy, and a primipara. It was 1.30 A. M. Her pains at that time were only cervical. With an aseptic finger I found the dilating os of about the size of a half dollar. At 2 A. M. I found rapid progress. At 3 A. M. the amniotic fluid was discharged. At 3.30 A. M. I found a vertex presentation, with a left occipito-sacro-iliac engagement, muscular contractions strong and rapid, pulse firm, "and every prospect brightened." At 4 A. M. she suddenly and unexpectedly began to look pale, her pulse was rapid and nervous, a cold sweat broke out, and a sudden anxiety seized both patient and doctor—now both in travail. On vaginal examination, I found on the left and outside of the vagina, in the cellular tissue and on a level with the cervix, a mushy mass which I diagnosticated at once as blood, and the fœtal occiput was impinging on it. At 4.30 the mass and head seemed of about the same size, and so vigorous and rapid were the uterine contractions and so firm was the resisting mass, that the previous vertex had become a face presentation, or so much so that the face and chin could be clearly outlined. Satisfied that the child could never be born till the mass was removed, I resolved to aspirate it; and while I was directing the servant to bring my instruments a strong uterine muscular contraction ruptured the vaginal wall from the lower third through to the left ischio-rectal fossa, discharging the most blood from the triangular space between the ischio-cavernosus and the transversus perinæi muscles, a wound three inches and a half long, and deep, with another rupture from this diverging outward toward the extended leg an inch and a half, making a large and ugly wound, out of which the fresh blood gushed with great force at first and flowed freely until the expulsion of the fœtus. On my pressing the fœtal face up at once, the

occiput, now having ample room, rotated favorably during the next contraction, and the following contraction expelled the child, and the hæmorrhage ceased.

The collapsed state of the patient was now distressing. The pulse was hardly countable, the temperature was 96°, and the respiration was 11, with *besoin de respirer*, sighing, begging for help, bidding friends farewell, and sinking into a semi-unconscious state, covered with cold perspiration. A carbolized absorbent cotton pad was placed over the wound, the head was lowered, windows were opened, hot bottles were placed about the patient, hot milk diluted was freely and frequently administered with stimulants, and a subcutaneous injection of morphine, a quarter of a grain, with atropine, was given. Superficial rubbing and stimulation were vigorously pushed, and the patient was carefully watched by my colleague, Dr. Spaulding, and myself for five hours uninterruptedly before we felt it safe to leave her. We again sponged her body with a solution of bichloride of mercury, packed the vagina with carbolized absorbent cotton (1 to 60) to prevent infecting the wounds, irrigated them with carbolized hot water, and packed them with iodoform gauze—for they were deep—having previously shortened them with three deep sutures. Three times daily we used the vaginal douche with a carbolic solution, and repacked tightly with carbolized cotton, after which we irrigated the wounds and repacked them, being careful always not to unpack the wounds till after cleansing and repacking the vagina. The patient continued to improve, and after the "milk fever" we freshened the edges of the remaining wound and put in four more deep sutures—seven in all—and secured perfect union with complete recovery. The source of this quantity of fresh blood was not discovered.

Knowing how helpful one's experience may be to another, I have prepared this imperfect article not for those who have had more, but less, experience in the anxieties of obstetrics.

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